GGS Care Home Limited

Thornton Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This comprehensive inspection was unannounced and took place on 31 July 2017.

At our last inspection on 13 March 2017, the home was rated as requires improvement in the key questions of effective, responsive and well-led. The home was rated as 'good' in safe and caring. This meant the overall rating was 'Requires Improvement.' We brought the inspection forward due to concerns received regarding the standard of care provided to people at Thornton Lodge.

During this inspection, we found six breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 in regard to person-centred care, dignity and respect, safe care and treatment, premises and equipment, good governance and staffing. We served a warning notice for regulation 12; safe care and treatment and regulation 17; good governance. You can see what other action we took at the end of the full version of this report.

Thornton Lodge Care Home provides 24 hour nursing and /or personal care for up to 34 older people, including care for people living with dementia. It is close to local amenities with good access to public transport and motorway networks.

At the time of the inspection there was no registered manager in post. The previous registered manager left on 11th July 2017 and the new manager took up post on 25th July 2017 and intended to register with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that there was not enough suitably trained and experienced staff on duty to meet people's social, emotional and physical needs. Staffing levels were not calculated using a formal calculation based on the needs of people using the service. During the inspection, we observed staff were ineffectively deployed which resulted in people being left for prolonged periods of time and their care needs not being met timely. Following the inspection, the provider contacted us to inform us that a formal dependency tool had been implemented to calculate staffing requirements. This will be followed up at our next inspection to determine that staffing has been provided in line with people's assessed needs.

We identified serious concerns regarding risk management that we immediately fed back to the provider. We found risk assessments were not in people's care files but stored electronically with only nursing staff and senior care staff having access to the electronic system. This meant care staff did not have access to the identified risk in order to mitigate the risks and provide safe care.

People were not protected from the risk of aspiration and were given foods by staff which could cause them to choke. We observed the food provided to one person had been identified as a food the person was to

avoid when they had been assessed by SALT (Speech and Language Therapy). We saw this person had also been given food not consistent with their assessed needs on days prior to the inspection indicating that this was not an isolated occurrence. We saw 'Resource' which is a thickening agent left accessible to people on the nursing floor which presented the risk of people consuming this accidently and placing themselves at risk.

Staff recruitment was robust, with appropriate checks carried out before staff began working at the home.

The environment did not meet good practice guidance for supporting people living with dementia. The upper floor was small and could not accommodate the number of people living on the nursing floor in the dining room or lounge area. The residential floor had a large and spacious lounge, dining area and an additional large quiet room. However, only two people were supported from the nursing unit downstairs to the residential unit to access these areas. The provider told us this would be addressed following the inspection and that everybody would be offered to go downstairs if this was their preference.

Upstairs, we found lighting was poor on the corridor with a number of light bulbs needing replacing which led to dimly lit corridors making visibility difficult for people with visual and memory impairment.

We identified issues with the overall décor and maintenance of the home. Paintwork and furnishings were dirty and although we saw the domestic cleaning during the inspection, there was no oversight or clinical infection control measures or audit undertaken by the management or provider at the home.

We saw broken and damaged fixtures and fittings, including the bathroom and a number of bedroom ceilings which had water damage caused by a leak. We saw there was a note on the bathroom door indicating that the light was not to be turned on. We asked a member of staff why the light was not to be turned on and was informed it was due to a leak that had come through the light fitting. We requested the door was locked as a matter of precaution and safety to people living at the home.

The people we spoke with during the inspection lived on the residential floor as the people on the nursing floor were living with advanced dementia and were unable to verbalise their experiences. The people we spoke with during the inspection spoke highly of the staff and the care provided. However, although we don't dispute the experiences of the people we spoke with, we observed differences during the inspection on how the nursing and residential floor operated. Our observations of care staff interactions on the residential floor were positive. The majority of care staff interactions on the nursing floor were good but we observed one care staff member did not communicate with people or ask for people's consent before doing care tasks and we noted people's distress at having a tabard put over their head or taken off without reassurance or explanation.

We noted two people on the nursing unit that should have been wearing hearing aids and glasses. However, neither person had these throughout the inspection.

People and their relatives had not been formally involved in initial assessments or reviews. However, we received mixed feedback from relatives regarding this. One relative told us they felt communication was good and that they were frequently consulted and involved in decisions about their family members care. Whilst a second relative didn't feel the staff were responsive to their family member's needs and didn't feel their family member was receiving safe care. They told us they had raised a number of concerns with the management but nothing had changed.

We found people's biographical information; likes and dislikes, were not consistently captured to support

person-centred care planning. The provider told us this information was captured in the activities file but when we looked at this, we found that none of the booklets had been completed.

People were not supported to live full and active lives. There was no stimulation or attempts made to engage people in meaningful activity. We observed people sat in the lounge on the nursing floor for long periods of time with no staff presence. The television remained on one channel with no consideration as to whether the programmes were appropriate or of interest to the people sat in the lounge. Our observations of staff engagement on the residential floor were more positive and we noted that there was a continued staff presence in the lounge which meant people were not left without staff support.

Accurate and contemporaneous records were not maintained. This included food and fluid records, weight monitoring, oral hygiene, nail care, fluid consistency and life history information about people living at the home.

We identified significant shortfalls in the quality of the care provided to people living at the home. The provider did not have a system in place to assess the quality of the service. There were no governance systems to monitor people's dietary needs, risk assessments and care plans, the environment, staffing or observations of the quality of care provided. These were areas of concern that we identified during the inspection. This meant the provider was not meeting their regulatory requirements.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People at risk of choking did not always receive specialised diets which had been advised by SALT (Speech and Language Therapy), meaning there was a risk of aspiration. We found the supplement 'Resource' which is a prescribed thickening agent was left accessible to people at the home meaning there was a risk this could be consumed unsafely.

Individual risks to people who used the service were not accessible to care staff.

The provider had failed to deploy sufficient numbers of staff which affected the quality of the care provided and had exposed people to the risk of harm.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not consistently ascertain people's consent before providing care or support.

People's nutritional needs required improved monitoring and records needed strengthening to demonstrate people's requirements were being met.

The environment did not meet good practice guidance for supporting people living with dementia.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and their visitors shared mixed experiences of the care and support received.

We observed some of the staff did not always interact with people who used the service in a manner which promoted their human rights and protected their privacy and dignity.

There were no prescriptive visiting times which meant relationships that mattered to people were promoted and maintained.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People could not be assured that they would receive the support they required as care plans did not contain accurate, up to date information about the support people needed.

People were provided with minimum opportunity for social activity but were supported to maintain relationships with family and friends.

There were systems in place for people and visitors to give feedback about the service, raise issues and concerns and there were systems in place to respond to complaints.

Is the service well-led?

Inadequate

The service was not well-led

The systems for checking the safety and quality of the service were ineffective or not in place, which placed people at risk.

The provider had failed to provide quality assurance or oversight of the home which had resulted in regulatory breaches.

The management team were responsive to feedback and swift action was taken to address some of the areas of concern raised during the inspection

Thornton Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We carried out the inspection because we had received an increased number of concerns regarding the safety of people using the service and the quality of the care provided.

The inspection was carried out on Monday 31 July 2017 and was unannounced. This meant the provider did not know we would be visiting the home on this day.

The inspection was undertaken by two adult social care inspectors from the Care Quality Commission (CQC) and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of our inspection planning we reviewed all the information we held about the home. This included previous inspection reports and any notifications sent to us by the home including safeguarding incidents, expected/unexpected deaths and serious injuries. We also reviewed the PIR. This is a document where the provider can state any good practice within their service and how they ensure their service is safe, effective, caring, responsive and well-led. We liaised with the local authority and local commissioning teams.

At the time of this inspection there were 32 people living at the home.

During the visit, the inspection team spoke with the manager and the husband of the nominated individual. We also spoke with a nurse, senior care assistant, a care assistant, the chef, and nine people living at the home, three visitors and a visiting healthcare professional. For the purpose of the report, we have referred to relatives as visitors in the body of the report to maintain their anonymity.

As part of the inspection, we looked around the building and viewed records relating to the running of the home and people's care. This included six care files, five staff personnel files and five medication

administration records (MAR).

We observed how staff provided care and support to people living at the home. We also observed breakfast and lunch being served to see how people were supported to eat and drink.

Inadequate

Is the service safe?

Our findings

The people we spoke to told us they felt safe living at Thornton Lodge and well looked after. One person said "I prefer it here than when I was at home as I had some falls then and I haven't had any here." We received mixed feedback from relatives, with one relative expressing high praise for the staff and the other relative expressing concerns for their relative's safety.

Although people told us they felt safe, we found risks to people had not always been assessed and managed safely. The risk assessment system in place at the time of the inspection did not enable the provision of high quality, safe care. The provider had implemented an electronic system which meant people's risk assessments and care plans were on the computer. We asked care staff how accessible the electronic records were to establish how care staff managed people's risks and had access to people's most up to date care plans. The care staff told us that they did not have access to the computer. This was confirmed by the nurse and senior carer who told us that only nurses and senior carers had a password to use the computer. We looked in six care files and found there were no risk assessments in any of the care files we looked at. In five care files, care plans had been printed but we found these were not up to date or the most recent care plan. In one of the care files we found there was no care plans and the person had complex needs which meant care staff had not had access to the required information to manage the risks.

We also found people's risks were not appropriately managed, which had exposed people to the significant risk of avoidable harm. We observed a person at breakfast and dinner that we were aware had been assessed by SaLT (Speech and Language Therapy Team) as having an 'unsafe swallow' and requiring a 'fork mash' diet in order to mitigate the risk of the person choking or aspirating. Aspirating is when food or drink goes down the windpipe and enters the lung.

The SaLT recommended the consistency of the person's drinks and that the person required supervision when eating. The person had been given toast and jam, which had been identified on their SaLT assessment as a texture the person was unable to chew. At dinner, the person was given fish fingers which was not consistent with a 'fork mash' diet. We looked through the person's food and fluid records for the week prior to the inspection and found that the person had received foods not consistent with a 'fork mash' diet on five occasions. The person was also left in the dining area unsupervised for prolonged periods throughout breakfast which meant the person had been exposed to the risk of harm.

People are prescribed their own thickening agent for their drinks as it is a prescribed medicine and the directions for the use of the thickener is printed on the label on the person's tin. We observed staff using one person's 'resource' thickener to thicken four people's drinks rather than use each individual person's thickening agent. This meant staff making drinks did not always have written information about the consistency to make people's drinks, which meant people were at risk of being given inadequately thickened drinks. We questioned care staff on the day of the inspection and they told us they knew how to thicken people's drinks correctly. However, we observed one person drinking a drink that should have been 'custard thick' consistency but we saw the staff member had not waited sufficient resting time for the drink

to achieve that consistency before giving it to the person. This meant it was too thin when the person was drinking it. The records about the use of thickener were inconsistent which meant it could not consistently be determined that people's drinks had been thickened as required.

We also observed 'resource' thickening agent was not stored safely. A patient safety alert had previously been issued by the NHS due to this supplement being consumed unsafely which had caused a person to choke and die. We saw 'resource' was left next to the sweetener and powdered milk in the dining room on the nursing floor. People living with dementia were left for prolonged periods in the dining room on the nursing floor so we asked the nurse during the inspection to lock the thickening agent in the clinic to maintain people's safety.

We saw one person required their fluids restricting, and daily weights taken as this was a medical requirement. However, we saw the person throughout July 2017 had exceeded the fluid restriction on eight occasions and no explanation was recorded to determine why this had occurred. The person required daily weighing but there were 22 occasions between May 2017 and the inspection date that the person had not been weighed. This meant staff had not followed medical recommendations to mitigate the risks in respect of the person's medical condition.

This was a breach of Regulation 12 (1) Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have an adequate risk assessment process in place, people's risks had not been managed in line with recommendations and 'thickening agent' was left accessible to people which had placed them at risk.

We asked people and their relatives whether there were sufficient numbers of staff on duty to meet people's needs. One person said; "There are not enough staff on especially at night as a lot of people need help going to bed and that requires two carers and if I ring the call bell you can wait ages." A relative said; "There are supposed to be four staff on the nursing unit but whenever I visit, I'm lucky if I see two." Staff told us they felt they could manage with the numbers of staff deployed but felt it would be better if they had the same number of staff in the afternoon as in the morning.

On the day of the inspection, there was a nurse and three care staff on duty until 14.00 on the nursing unit. At 14.00, one of the care staff left leaving the nurse and two care staff. This was the same staffing compliment on the residential floor but there was a senior carer instead of a nurse. The provider told us staffing levels were calculated using a dependency tool. However, we found there was nothing completed in people's care files to determine the degree of people's dependency. We asked to look at the dependency tool used and found that this did not calculate care hours based upon the needs of people living at the home. During the inspection, we observed on the nursing unit that people were left for long periods of time during breakfast and in the lounge with no staff presence to monitor their needs and ensure their safety.

On the residential floor, we observed deployment was more effective as one member of staff remained in the communal lounge at all times but the majority of people required two to one support and although people's safety was not compromised, people had to wait to have their care needs met. We also observed the senior carer was frequently interrupted whilst administering medicines to observe people in the lounge whilst the care staff supported people to the toilet.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have a system in place to ensure sufficient numbers of suitably qualified staff were deployed based on the needs of the people living at the home.

Following the inspection the provider contacted us to inform us that they had an extra member of staff working between the two floors. This will be followed up at our next inspection.

We identified issues with the overall décor and maintenance of the home. We observed there was sensor lighting on the corridors, toilets and communal rooms. A number of light bulbs on both the upstairs and downstairs corridors were not working. This meant some areas were dark and could have affected safe mobilising and increased the risk of falls.

We saw paintwork and furnishings were dirty and although we saw the domestic cleaning during the inspection, there was no oversight or clinical infection control measures or audit undertaken by the management or provider at the home. There was an unpleasant smell in two of the bedrooms on the residential floor and outside two bedrooms on the nursing floor. The corridor carpet was heavily stained. The bedrooms and corridors on both floors were tired and dated and required decorating.

We saw broken and damaged fixtures and fittings, including the bathroom and a number of bedroom ceilings which had water damage caused by a leak. We saw there was a note on the bathroom door on the nursing unit indicating that the light was not to be turned on. We asked a member of staff why the light was not to be turned on and was informed it was due to a leak that had come through the light fitting. We requested the door was locked as a matter of precaution and safety to people living at the home.

We checked safety procedures in the home and that maintenance and risk assessments were completed in line with requirements. We saw fire risk assessments had been completed and people had personal emergency evacuation plans (PEEPs) in place. The PEEP provided information regarding the person's assessed abilities in the event an evacuation of the home was required. There was a fire risk assessment in place dated July 2017 but according to the assessment, the last fire drill was done October 2015 and staff hadn't had fire training since June 2014. We could also not find any confirmation of checks being completed of call points or emergency lighting.

We found all safety certificates in place and up to date. For example; gas and electric but we found the hoists service had been due April 2017 and had not been completed.

This was a breach of Regulation 15 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, premises and equipment.

We looked to see how accidents and incidents were monitored and whether control measures were implemented to reduce the risk of re-occurrence. We saw that falls were monitored and triggers or trends were identified and evidenced. We saw learning from incidents or investigations took place and appropriate changes were implemented, including the action taken to minimise the risk of further incidents. The home had also been proactive in requesting the falls team to attend the home and had an initiative in which they had looked at people's zimmer frames and implemented measures to make things safer for people when mobilising.

The home was part of a programme called Safer Salford and we were told by the facilitator that the home had been active, engaged and committed to the initiative. Thornton Lodge along with eight other care homes are involved in this pilot quality improvement project which aims to improve resident safety by getting staff to test out small innovative changes and share best practice.

We looked at the system in place to safeguard people from abuse and improper treatment. There was a safeguarding policy in place and staff understood the procedure to follow if they felt that people might be at

risk of abuse or harm. The staff members we spoke with described what action they would take if they had concerns about people's safety. One member of staff said; "We've done training in this, it was in two parts. First thing I would do is report anything to the manager."
Whistleblowing information was in the staff handbook and staff told us they would refer to this if the need arose.

We looked at five staff personnel files and saw that staff had been recruited safely and the required recruitment checks had been carried out prior to them starting work at the home. Staff had produced evidence of identification, had completed application forms with any gaps in employment explained, had provided employment references and a Disclosure and Barring (DBS) check had been undertaken. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups. New starter checklist in place which lists each step of process and signed and dated when documentation has been seen or received, to ensure all required information is on file. We also checked nursing staff registration was up to date and found the provider had an effective system in place to monitor this.

Requires Improvement

Is the service effective?

Our findings

We asked people if the staff had the required skills and sufficient knowledge of their needs to provide effective support. One person said; "The staff are lovely all of them and very helpful." Two people told us; "The domestic is fantastic, they work very hard and always have a lovely smile and are helpful."

We looked at the induction programme and found this had not been introduced in line with the Care Certificate. The Care Certificate is a set of standards that social care and health workers maintain to perform their duties. It is the new minimum standards that should be covered as part of induction training of new care workers. The induction in place covered introduction to the service, systems, and processes but there were no actual training sessions. This meant new staff had not been adequately supported or assessed to determine they demonstrate the required level of competence to carry out their role unsupervised.

We looked at the training matrix to determine the professional development staff received to ensure they were fully supported and qualified to undertake their roles. The training matrix we received during the inspection had minimal training indicated as being completed. However, we saw training certificates in staff personnel files confirming training that had been completed which was not documented on the training matrix. We asked the manager to contact the previous registered manager to determine that we had been given the most up to date training matrix.

Following the inspection we were sent a training matrix that recorded training had been undertaken in: basic life support, COSHH, DoLS, MCA, dementia, first aid, fire safety, food hygiene, health and safety, infection control, moving and handing theory and practice, safeguarding, challenging behaviour awareness, equality and diversity, dignity through action, end of life care and catheter care. However, we noted the majority of training listed on the matrix had been undertaken in 2015 and there were still significant gaps on the matrix indicating that out of 35 staff; 12 staff had not received training in; deprivation of liberty (DoLS), first aid, health and safety or moving and handling practical training. The moving and handling practical training was also outside the required time frame for all the staff. We found 10 staff had not completed basic life support or COSHH and this included the domestic. Eight staff had not done fire safety and despite the home being registered for people living with dementia, 14 staff had not received dementia training.

We found that staff were not effectively supported to undertake training, learning and development to enable them to fulfil the requirements of their role. This is a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in respect of staffing.

During the inspection, we discussed training with the provider and outlined our concerns regarding the initial training matrix we had been given. Whilst we were undertaking the inspection, the provider arranged for a moving and handling trainer to attend the home on 07 and 08 August 2017 to provide practical moving and handling training to all the staff. The provider also purchased an online training package. Although we acknowledge the provider was proactive in sourcing this training, we have maintained there was a breach of the regulation as it was the inspection team that identified the shortfall and there was no timeframe that the

deficit would be addressed. This will be followed up at our next inspection.

Staff had been provided with regular supervision and had an annual appraisal of their work performance. Staff had received two supervisions up to the time of inspection and there was a standardised supervision and appraisal from in place which confirmed they had been conducted and completed in line with the home's policy.

We saw two notice boards in use on the nursing floor which were unorganised and although important monitoring information was included on the board it was not easily identified. The chef also had a white board in the kitchen which detailed people's needs to ensure they prepared the food in line with recommendations. However, when we cross referenced what was documented in each of these places, we found discrepancies between what was documented in people's care plans, the nursing white board and the chef's board.

We found staff had been proactive in referring people to other healthcare professionals which included speech and language therapy (SaLT) and the dietetic service when people were deemed to be at risk of choking or losing weight. However, we identified gaps in the food and fluid records which meant we were unable to determine that people had been provided fortified food and fluids in line with their dietetic action plans.

This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider could not demonstrate through documentation that they were meeting people's nutritional and hydration needs.

We observed the breakfast and lunch experience on the nursing floor and lunch on the residential floor. We found the dining experience required improvement on the nursing floor. The dining room was small on the nursing floor with one table that could only accommodate four people. There was a spacious dining room on the residential floor but at the time of the inspection people on the nursing floor were not given the choice to eat their meals there.

People were seated in the dining room 30 minutes before the food trolley arrived. At breakfast the staff member did not ask people whether they wanted to wear a tabard to protect their clothing. We observed one person became distressed as this was just put over their head without explanation. At the end of meal time service, the staff member did not inform people before removing the tabard and the person shouted and told the staff member; "Give that back, it's mine." This was again observed at lunch when this staff member put tabards on people However, other staff members were observed to ask people and explain what they were doing.

At breakfast people were not given a choice of which cereal they had, this was told to the person as it was put in front of them. People were asked if they wanted a 'cup of tea' but there was only one cup provided and the staff member did not offer any refills or an alternative drink. At lunch we observed people were offered a choice of tea and orange cordial. We saw one person asked for, and was given both. People were offered toast and jam which was provided and further slices of toast were offered. The staff member left people and returned with a banana for one person. Nobody else was offered fruit or whether they would also like a banana.

At lunch we observed one person had been sat at the table but they were then moved and sat away from the table to accommodate another person being seated at the table. Staff told the person; "[name] is able to feed themselves, whereas we need to help you." We observed the person who was moved from the table, sat

with their tabard on, 30 minutes without being given any food as they had to wait until the staff member had finished supporting another person, before they helped them to eat. This person had been the first person in the dining room, but they were the last person to eat.

At both meal times' we saw people were left for long periods of time without any staff presence which meant people that required reassurance and support looked to other people to provide this. One person was confused and repeatedly asking other people present when they were going home. This caused another person to be verbally abusive to the person which caused the person to escalate further.

At lunch on the residential floor, we saw the majority of people sat in the dining room and the tables were set with tablecloths, cutlery and paper towels. Some of the people were given plastic aprons to protect their clothing.

Two members of staff were in the dining room throughout the lunchtime period and the meals were served by the kitchen staff. The meal served was shepherd's pie and vegetables followed by bread and butter pudding and cream. Plate guards were given to people as required and staff were observed to provide assistance when needed. The staff present spoke to people and encouraged them to eat, they cut people's food up and spent a lot of time talking and gave people time. We also saw that culturally appropriate menu options were provided.

On the residential floor, the manager also assisted and encouraged people to eat. We observed two people didn't like the hot meal and the manager made them cheese sandwiches which they ate. One person requested prunes which were provided. On the residential floor, the lunchtime appeared well organised, structured and relaxed.

We looked to see how people's freedom of movement was promoted. One person told us they didn't feel restricted as there weren't lots of rules and regulations. They said; "As long as I let them know if I am going out they are ok with that."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed.

When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The management had created a DoLS matrix to monitor applications to the local authority which confirmed they were submitting authorisations timely and informing the required public bodies when an authorisation had been granted. DoLS had been applied for appropriately and were in place for the people who required them.

Where people had a DoLS or Do Not Attempt Cardiopulmonary Resuscitation (DNAR) in place, we saw this was in the person's care file and there was a discrete symbol used on people's doors to signify this which all staff were aware of.

Staff had not completed recent training in this and some staff had not received training at all. Staff demonstrated only a basic understanding of the principles of the Mental Capacity Act (MCA) and required training and a better understanding to support them in their role.

At our last inspection of the home we had seen little evidence that the building had been adapted to meet the needs of people living with dementia. During this inspection we found that no additional adaptations had been made. As at the last inspection we found it difficult to find our way around the home easily, no pictures or signs were prominently available to help people living there find their way around or identify their bedroom or bathrooms easily. The provider indicated they would look in to this in conjunction with the décor, poor lighting the environmental issues we raised.

Requires Improvement

Is the service caring?

Our findings

People who lived at the home told us they were well cared for and looked after. Some of the comments included; "The staff are lovely all of them and very helpful."; "All the staff are brilliant. They know me and are very good. They look after me. I can talk to them."; "The staff know me and call me by my Christian name."; "The staff call me by my first name. They are all friendly. I can ask any of them to help me and they do help."

We found widespread and significant shortfalls in the home, which meant peoples' immediate and on-going care needs were not consistently met to demonstrate a caring culture. Whilst we found some staff had good intentions, they were not supported by the overall systems in the home to ensure that people received safe care. For example; people's wishes and preferences were not consistently met and people with nutritional needs had been left unattended when eating which could have resulted in significant harm to the person.

We observed on the nursing floor people were not always given a choice by staff about how they wanted their care to be delivered. We saw people were not given a choice at breakfast where they sat, what they ate or what they had to drink. One person was observed at breakfast to have finished their drink and when another person at the table asked if the person could be provided with another drink, the staff member responded by saying; "[Person's] had one." No further drink was given and the person was taken out from the dining room. On the residential floor our observations were more positive and people told us they were provided choice and that their choice to eat in their bedroom rather than the dining room was respected.

We saw occasions during the inspection on the nursing floor that the care and support people received was rushed and task focused. People were dressed in the morning and then just taken to the dining room where they had to sit and wait some time with no explanation given by staff. People were placed in wheelchairs and sat waiting on their own wherever there was space whilst they waited for their relative to take them out. On the residential floor, we saw one person in their bedroom at 15:00 still had their lunch plate on their knee with the remains of their lunch which had been served at 13.00.

We found staff were rushed in the morning on the nursing floor getting people up and supporting their personal care needs. This resulted in things being missed and staff not having taken in to account and met people's communication needs. For example; we noted two people on the nursing floor required hearing aids and glasses. We noted neither person had these throughout our inspection. One of these people was visited by their family member during the inspection who noted that their relative did not have their hearing aids or glasses. We observed the person's family member looking for their relatives' hearing aids and glasses and we confirmed with them at the end of our inspection that they had not been found. We noted three pairs of glasses on the mantelpiece in the lounge, a pair of glasses in the nursing office and a pair of glasses in the dining room. During our inspection we did not observe staff attempt to determine who these glasses belonged too.

This was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) with regards to dignity and respect.

We looked to see how staff promoted people's independence. A relative gave high praise to the staff for the commitment they had shown to their family member to support them to mobilise again. The relative told us their family member had been bedbound for some considerable time prior to their admission to Thornton Lodge and they had not envisaged it possible that their family member would walk again. We saw the person independently mobilising throughout the inspection with the use of a frame which was of great benefit to maintaining their independence and promoting their freedom.

There were no prescriptive visiting times which meant people's relatives and friends were able to visit when they wanted. This promoted people maintaining relationships with people that mattered to them.

We looked to see how the staff promoted equality, recognised diversity, and protected people's human rights. People confirmed they were able to practice their religious beliefs. Some people told us the Jewish religion and way of life was important to them and they felt that this was facilitated. There were weekly visits from the local Rabbi and Jewish festivals were promoted and celebrated. Kosher meals were sourced from a local supplier for people that wanted this. Some residents opted to follow a vegetarian diet and told us they were happy with the vegetarian food that was provided. However, there was no assessment completed to capture information regarding people's religion, customs, sexuality and relationships. The provider gave us other examples of how they have met people's individual needs to demonstrate this was being considered and met despite documentation not lending itself to determine this.

We asked the management how they cared for people nearing the end of their life. We saw some staff had undertaken 'six steps' training in end of life care. The six steps programme is a North West end of life programme that helps people nearing the end of their life to remain at the home cared for in familiar surroundings by people they know and trust. We saw there was a six steps register in place on the nursing floor which contained a list of people who had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place and detailed when the DNACPR was due to be reviewed.

Regular meetings were held to discuss all the people who are listed on the register and to determine which step people were considered to be on. At the meeting; nurse and manager discussed each person, their mobility, weight, appetite and generate any actions needed based on feedback. People beyond step one had a six steps supportive care record in place along with a review sheet which was updated monthly to reflect any changes.

Requires Improvement

Is the service responsive?

Our findings

People could not be assured they would receive person centred support that was based upon their individual interests and preferences. The quality and quantity of information in care plans about people's background, interests and preferences was inconsistent. The provider told us the information was captured in 'my journal' which we were told the activities coordinator kept in a file in the activities cupboard. We asked the activities coordinator to show us the completed booklets. The booklets were specifically designed to capture this information and daily activities that people had participated in. None of the biographical information had been completed in any of the booklets we were shown. Whilst some people's electronic care plans contained information about their preferences this was not always the case and care staff did not have access to the electronic care records that had been completed which meant they were unable to demonstrate care was being delivered in line with people's wishes.

We noted one person's social needs assessment indicated that the person preferred to eat in the company of others at meal times in the dining room. We observed this person's preference was not accommodated throughout the inspection as they were supported to eat in the lounge after everybody else had eaten in the dining room.

A relative raised concerns with us during the inspection regarding people's preferences not being met regarding when people went to bed and got up in the morning. The relative told us that they observed people being 'put' to bed as early as 18.00 and they told us when they had challenged care staff regarding their observation, care staff told them that they had been told to do this by the nurse. This had been raised as a concern by another relative at our previous inspection in March 2017 but it was not substantiated by people living at the home when they were asked. During this inspection we asked people again and were told their choice was adhered to as to when they went to bed and got up in the morning. However, it was only people on the residential floor that were able to answer our questions regarding the care provided and they would not be aware as to the times people were going to bed on the nursing floor.

We looked to see how people were provided opportunities to engage in social stimulation and activities of their choosing. The home employed an activities coordinator but due to a shortage of care staff they were required to fulfil care hours at the time of the inspection. We saw the activities coordinator encouraging people to take part in armchair aerobic activity on the residential floor and saw the activities coordinator motivated people in the lounge to join in. We saw the majority of the people did participate in the activity and they were observed to enjoy it. However, this was the only activity we observed during our inspection. For the remaining time, we saw 13 people in the lounge and their only source of stimulation was the television, only two people were observed to watch the television and most of the people would have had difficulty hearing it due to the volume and their distance from it.

On the nursing floor we observed people sat around and saw little stimulation offered to people. The interactions we observed were task focused interventions. For example; supporting people to attend meals, to the toilet or dispensing medication. One person that was mobile on the nursing floor went downstairs to the residential floor and was able to participate in the activities and received the mental and physical

stimulation they required on a regular basis. However, this was not provided to the remaining people on the nursing floor and we did not observe any activities taking place or scheduled for people living with dementia such as reminiscence or for those people who were cared for in bed who would benefit from one to one time.

The staff completed daily 'comfort in care' sheets for each person who lived at the home. These included information about washing (am and pm), oral care, hair care and nails to support that people's care needs were being met. We found conflicting information documented on one person's records as the care plan stated the person required one staff member for all care tasks but the 'comfort in care' sheets had not been completed and indicated 'self'. We were also unable to ascertain people's preference regarding their care needs. For example; whether the person had a gender preference regarding who supported them, whether they preferred a bath or shower and how frequently they wanted these.

People's care files lacked information pertaining to their personalised care pathway and there was little stimulation and activity provided to people. This was a breach of Regulation 9(1) (of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked to see how staff managed people's pressure care. We observed people had pressure relieving cushions and mattresses in place. However, staff understanding of the use of this equipment was limited. We observed during the inspection a person was wearing inflated foot supports for pressure relief. We saw one of the inflated boots had been put on by care staff the wrong way round and this remained incorrectly positioned until family visited and corrected the boot. A staff member told us; "We try to do pressure relief every three hours, either get people to walk or turn them in bed, it doesn't always happen that often as sometimes get stuck supporting people." We informed the manager and provider of our observations and they indicated they would request the tissue viability nurse (TVN) provide guidance regarding this.

People living at the home and relatives were asked for their views and opinions about their experience of the home. There was a box situated in the foyer for people to make their suggestions.

The home had a complaints process in place to handle and respond to complaints. We saw the provider had a policy and procedure in place and the management told us people were given this information when they first moved in to the home. The complaints procedure was displayed in the home and people and relatives of people we spoke with confirmed they were aware of the complaints process and how to access information around making a complaint. People who used the service and their relatives had mixed views that should they have any issues that these would be dealt with appropriately. People told us they would approach the manager and felt they would resolve the issue or they would get their family member to complain for them. A relative told us they'd always found management to be responsive and communicated with them regularly. A second relative told us that they had raised issues but nothing improved and they felt their relatives care needs were not being met and they were concerned for their relatives' welfare.

Inadequate

Is the service well-led?

Our findings

At our March 2017 inspection, the home was rated as requires improvement overall and in the key questions for; effective, responsive and well-led. The home was rated as good in safe and caring. This inspection was brought forward due to concerns received regarding the standard of care provided to people at Thornton Lodge.

At this inspection, we found six breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 in regard to person-centred care, dignity and respect, safe care and treatment, premises and equipment, good governance and staffing. We served a warning notice for regulation 12; safe care and treatment and regulation 17; good governance.

The expectation would be that following the previous 'requires improvement' rating, the provider would have ensured the quality of care received had improved and attained a rating of either 'Good' or 'Outstanding' at this inspection. This had not been the case as we found the quality of care received had not improved which meant the quality of service provided to people living at the home was not continuously improving over time.

Staffing levels were not calculated using a dependency tool and we saw repeated examples of ineffective deployment which meant there was no staff presence in the communal areas on the nursing floor placing people at risk of not having their needs met.

Care staff did not have access to risk assessments or up to date care plans to mitigate risks and provide appropriate support in line with their needs. We saw in the upstairs office there were two notice boards in use which were untidy and there was no order or structure to how information had been displayed. We found important monitoring information was documented but this was not easily identified and there was information missing and inaccurate information recorded.

Poor record keeping meant that it was difficult to determine people were receiving the correct care and support. The manager acknowledged that care staff were not maintaining accurate records and said this had been raised at a recent meeting and would continue to be addressed through supervision and staff meetings.

We found the provider did not have a quality assurance system in place and provider audits were not conducted. We spoke with the provider during the inspection and ascertained that they visited the home weekly but they could not demonstrate that they had been maintaining oversight regarding the quality of care provided to people living at the home. The provider was unaware that care staff did not have access to the electronic system or that the journal containing peoples' biographical information was not being completed.

We looked at the management audits that had been conducted and found medicines audits had taken place weekly but the controlled drug audit had not been completed since 24 May 2017. The audits file

contained a section for care plan audits and resident of the day but both sections were blank. There was a section for infection control audits but the only audits completed had been by the local authority. The last local authority full inspection was in January 2017 which was followed up with a spot check in February 2017. There were no infection control audits or monitoring undertaken by the manager or provider.

We found safety certificates were up to date but maintenance of the hoists had been required in April 2017 and this had not been completed.

The new manager had only been in post a week so we asked them to contact the previous manager to ascertain if they had been completing audits. We received confirmation from the manager that the previous registered manager had been contacted and there were no further audits completed than what we had already been shown at the time of the inspection.

We found outcomes for people living on the nursing floor were poor and when we shared the concerns with the provider, we found that they had not been aware of them. We asked the provider why people on the nursing floor were not provided the opportunity to access the spacious communal areas downstairs and we were told that the nursing staff were reluctant for this to occur as they wanted to maintain oversight. We identified people's care was being delivered for the benefit of staff and not in regards to the person receiving the care and treatment. The manager contacted us following the inspection to inform us that people on the nursing floor were being provided the opportunity to eat their meals and access communal areas downstairs following the inspection. This will be followed up at our next inspection.

We found there were no processes in place to monitor the performance of the service to address shortfalls as they arose. We found the lack of strong leadership and provider oversight underpinned many of the failings we identified during our inspection.

This meant there had been a breach of Regulation 17(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not effectively assessed, monitored and improved the quality and safety of the services provided in the carrying on of the regulated activity.

The new manager had only been in post a week and so the failings could not be attributed to their leadership. They acknowledged that they needed to implement systems to address our findings and demonstrated a commitment to achieving high quality care for people living at the home. During the inspection they commenced looking at people's care files and cross referencing the information with the electronic records. We also found the provider to be responsive to our findings and they scheduled moving and handling training whilst we were undertaking the inspection for the following week. They also purchased an online training package so that all care staff would have access to on-going e-learning to maintain their competency. A clinical lead was also to be appointed to provide nursing leadership and oversight in support of the new manager.

Staff told us they felt supported effectively and that they received supervision and attended team meetings regularly. A staff member said; "Yes, we had one Thursday just gone, they are either monthly or every two months, I can't really remember. We can bring stuff up in the meetings and I feel we are listened too."

We noted the provider had a staff recognition award in place which saw a staff member being awarded 'employee of the month' this was an initiative intended to promote staff morale and acknowledge staff contribution to the home. We saw there was a ballot box in reception where people living at the home, relatives, staff and healthcare professionals could nominate a staff member working at Thornton Lodge. This was drawn monthly and the winning staff member received a £25 shopping voucher.

The service was involved with the safer care homes pilot called 'Haelo' which was a joint venture between the local clinical commissioning group (CCG), the local NHS Foundation Trust and the local city council. The primary purpose to improve population health and healthcare for local residents. The facilitator was complimentary regarding the management's engagement in the pilot and indicated that the home had been extremely active in their participation.

We were told by people living at the home and staff that the provider was approachable and regularly visited the home. We observed the provider with people on the residential floor and observed them to receive a very warm reception. The provider knew people by name and spent time speaking with people in the lounge.

We saw there was a business continuity plan in place and two local homes were identified as alternative locations where people could go in emergency. There was evidence in the file detailing the arrangements and agreements in place with both services.

As of April 2015, it is now a legal requirement to display performance ratings from the last CQC inspection. This should be both on any website operated by the provider in relation to the home and should be displayed conspicuously in a place which is accessible to people who live at the home. We found the ratings were laminated and displayed prominently on entrance to the home. This meant people living at the home and visiting families were made aware of the previous inspection rating and the quality of care being provided at the home based on our last inspection.

Providers are required by law to notify CQC of certain events in the service such as serious injuries, deaths and deprivation of liberty safeguard applications. Records we looked at confirmed that CQC had received all the required notifications consistently and in a timely way.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care files lacked information pertaining to their personalised care pathway and there was little stimulation and activity provided to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not have effective systems in place to maintain people's dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not maintained oversight of the environment; repairs, maintenance and infection control.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not have a system in place to ensure sufficient numbers of suitably qualified staff were deployed based on the needs of the people living at the home. Staff were not effectively supported to undertake training, learning and development to enable them to fulfil the requirements of

their role.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider did not have an adequate risk assessment process in place, people's risks had not been managed in line with recommendations and 'thickening agent' was left accessible to people which had placed them at risk.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider could not demonstrate through documentation that they were meeting people's nutritional and hydration needs. The provider had not effectively assessed, monitored and improved the quality and safety of the services provided in the carrying on of the regulated activity.

The enforcement action we took:

Warning notice